Charleston Earliest Settlers:

Who Came	Date Came	HBLM	Ped.	FGS	Pict.	Hist.
Charles Shelton						
Alexander Wilkins						

Others: Meeks Bottoms

Brot cattle & Built cabin
- Wm Madison Wall 1854
- Aaron Daniels "
- George Wash Bean "

Ref:

WASATCH COUNTY HOSPITAL
OUT-PATIENT AND EMERGENCY RECORD

2016

FAMILY NAME	FIRST NAME	MIDDLE NAME	HOME PHONE	ADMISSION DATE	TIME A.M. P.M.	HOSPITAL NO.
LUKE	KESLIA		654-1318	8/2		

ADDRESS	CITY	ZONE	STATE	BIRTH DATE MO. DAY YEAR	AGE	SEX M F	CIVIL STATUS M S W D SEP.	RELIGION
	HEBER			AUG 17 54	21			

NEAREST RELATIVE OR FRIEND EDWARD LUKE RELATIONSHIP HUSBAND

ADDRESS S/A PHONE

EMPLOYER ADDRESS PHONE

OCCUPATION BROUGHT BY HUSBAND

NURSES

INSURANCE INFORMATION

BLUE CROSS: CONTRACT NO. NONE GROUP NO. CODE

OTHER IDENTIFICATION NO.

INSURED THROUGH SELF ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ ADMITTED BY

ACCIDENT: INDUSTRIAL ☐ OTHER ☐ TIME OF ACCIDENT A.M. P.M. OTHER INFORMATION

WHERE AND HOW OCCURRED

ILLNESS: C. C.

ONSET

T. B.P. PULSE NURSE IN ATTENDANCE R.N.

PHYSICIAN

P. EXAM: c/o severe headache.

DX:

RX: Demerol 50mg ̄c Vistaril 50mg IM given as ordered by Dr Green (...) at 4 AM

FINAL DISPOSITION:

☐ HOME ☐ HOSPITAL ☐ OTHER

☐ RELATIVES ☐ POLICE ☐ CORONER NOTIFIED A.M. P.M. BY

☐ DR. EMERGENCY ROOM SERVICES $ SIGNED NC (PHYSICIAN)

OFFICE

CHARGES:

☐ Emergency Room $ 8.00

☐ Central Supply

☐ Laboratory

☐ X-ray

☐ Pharmacy

☐ Oxygen

☐ Other

TOTAL $

Paid in Full

Bill rendered to

Address

☐ Billed ☐ Paid Date

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THIS HOSPITAL, HEREBY AUTHORIZE DR. ______ (AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, AND TO PERFORM THE FOLLOWING OPERATION ______ AND SUCH ADDITIONAL OPERATIONS OR PROCEDURES AS ARE CONSIDERED THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID OPERATION. I ALSO CONSENT TO THE ADMINISTRATION OF SUCH ANESTHETICS AS ARE NECESSARY, WITH THE EXCEPTION OF ______. ANY TISSUES OR PARTS SURGICALLY REMOVED MAY BE DISPOSED OF BY THE HOSPITAL IN ACCORDANCE WITH ACCUSTOMED PRACTICE. I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT, THE REASONS WHY THE ABOVED NAMED SURGERY IS CONSIDERED NECESSARY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS, IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT, WHICH WERE EXPLAINED TO ME BY DR. ______.
I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.

SIGNATURE OF PATIENT

SIGNED FOR PATIENT BY Edward Luke

RELATIONSHIP Husband DATE TIME A.M. P.M.

WITNESS

REASON PATIENT CANNOT SIGN